FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: EMBASSY CARE CENTER, INC.

Address: 555 KAHLER ROAD (Number) WILMINGTON (City) 60481 (Zip Code)

County: WILL

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) LELAND J. COHN

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,280	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,306	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,586	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,631	929	1,547	5,107	8
9	SNF/PED					9
10	ICF	25,164	9,237		34,401	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,795	10,166	1,547	39,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.13%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 0201/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1,387

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

		MODIFIED CASH*		CASH*	
ACCRUAL	X				

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,327	16,256	7,800	227,383		227,383		227,383			1
2	Food Purchase		172,472		172,472	(20,917)	151,555	(441)	151,114			2
3	Housekeeping	108,189	25,381		133,570		133,570		133,570			3
4	Laundry	69,938	12,219		82,157		82,157		82,157			4
5	Heat and Other Utilities			96,357	96,357		96,357	2,873	99,230			5
6	Maintenance	43,967		93,774	137,741		137,741	(37,459)	100,282			6
7	Other (specify):*											7
8	TOTAL General Services	425,421	226,328	197,931	849,680	(20,917)	828,763	(35,027)	793,736			8
	B. Health Care and Programs											
9	Medical Director			12,500	12,500		12,500		12,500			9
10	Nursing and Medical Records	1,102,882	79,749	317,824	1,500,455		1,500,455	(2,161)	1,498,294			10
10a	Therapy	86,427	526	7,523	94,476		94,476		94,476			10a
11	Activities	141,503	15,065	3,701	160,269		160,269	(14,299)	145,970			11
12	Social Services	54,050		3,055	57,105		57,105		57,105			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,384,862	95,340	344,603	1,824,805		1,824,805	(16,460)	1,808,345			16
	C. General Administration											
17	Administrative	96,233		315,406	411,639		411,639	(265,566)	146,073			17
18	Directors Fees											18
19	Professional Services			100,790	100,790		100,790	6,920	107,710			19
20	Dues, Fees, Subscriptions & Promotions			24,704	24,704		24,704	(11,565)	13,139			20
21	Clerical & General Office Expenses	91,291	20,860	49,966	162,117		162,117	122,492	284,609			21
22	Employee Benefits & Payroll Taxes			341,270	341,270	20,917	362,187	26,398	388,585			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,495	1,495		1,495		1,495			24
25	Other Admin. Staff Transportation			11,066	11,066		11,066	9,000	20,066			25
26	Insurance-Prop.Liab.Malpractice			83,016	83,016		83,016	3,216	86,232			26
27	Other (specify):*											27
28	TOTAL General Administration	187,524	20,860	927,713	1,136,097	20,917	1,157,014	(109,105)	1,047,909			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,997,807	342,528	1,470,247	3,810,582		3,810,582	(160,592)	3,649,990			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

EMBASSY CARE CENTER, INC.
0038711
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	20,917	
2	FOOD		20,917

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number EMBASSY CARE CENTER, INC. #0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			37,848	37,848		37,848	137,738	175,586			30
31	Amortization of Pre-Op. & Org.							2,777	2,777			31
32	Interest			45,693	45,693		45,693	478,975	524,668			32
33	Real Estate Taxes			55,781	55,781		55,781	7,199	62,980			33
34	Rent-Facility & Grounds			533,645	533,645		533,645	(533,645)				34
35	Rent-Equipment & Vehicles							4,854	4,854			35
36	Other (specify):*											36
37	**TOTAL Ownership**			672,967	672,967		672,967	97,898	770,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,512	65,622	187,134		187,134		187,134			39
40	Barber and Beauty Shops			1,105	1,105		1,105		1,105			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,880	93,880		93,880		93,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		121,512	160,607	282,119		282,119		282,119			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,997,807	464,040	2,303,821	4,765,668		4,765,668	(62,694)	4,702,974			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,157	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(441)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,175)	21		18
19	Entertainment	(1,984)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(342)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,975)	21		24
25	Fund Raising, Advertising and Promotional	(9,896)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(88,630)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,286)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,408)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,408)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (62,694)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

EMBASSY CARE CENTER, INC.

ID# 0038711

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 5,529	6	1
2	Non Care Exp.			2
3	RE Tax	(3,072)	33	3
4	Interest	(9,990)	32	4
5	Depreciation	(3,846)	30	5
6	Capitalize Paint & Decor	(44,888)	6	6
7	Interest Income	(43)	32	7
8	Trust Fees	(1,015)	19	8
9	Veterans Exp	(2,161)	10	9
10	ICLTC - COPE	(108)	20	10
11	From Embassy Bldg			11
12	Trust Fees	(150)	21	12
13	Amort of Mtge Costs	(5,630)	32	13
14	Day Training	(14,299)	11	14
15	Legal bills prior to 12/99	(8,957)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(88,630)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(441)											(441)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,873									2,873	5
6	Maintenance	(39,359)	514	1,386									(37,459)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(39,800)	514	4,259									(35,027)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,161)											(2,161)	10
10a	Therapy													10a
11	Activities	(14,299)											(14,299)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(16,460)											(16,460)	16
	C. General Administration													
17	Administrative			(265,566)									(265,566)	17
18	Directors Fees													18
19	Professional Services	(10,314)		17,234									6,920	19
20	Fees, Subscriptions & Promotions	(11,988)		423									(11,565)	20
21	Clerical & General Office Expenses	(9,300)	782	131,010									122,492	21
22	Employee Benefits & Payroll Taxes			26,398									26,398	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			9,000									9,000	25
26	Insurance-Prop.Liab.Malpractice			3,216									3,216	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(31,602)	782	(78,285)									(109,105)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,862)	1,296	(74,026)									(160,592)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	45,311	78,862	13,565									137,738	30
31	Amortization of Pre-Op. & Org.		2,777										2,777	31
32	Interest	(15,663)	491,389	3,249									478,975	32
33	Real Estate Taxes	(3,072)	3,072	7,199									7,199	33
34	Rent-Facility & Grounds		(533,645)										(533,645)	34
35	Rent-Equipment & Vehicles			4,854									4,854	35
36	Other (specify):*													36
37	**TOTAL Ownership**	26,576	42,455	28,867									97,898	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,286)	43,751	(45,159)									(62,694)	45

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule attached		Schedule attached		Schedule attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 533,645	Embassy Care Building Partnership		$	$ (533,645)	1
2	V	32	Interest Income		Embassy Care Building Partnership		(13)	(13)	2
3	V	32	Interest Exp Nsg Home		Embassy Care Building Partnership		452,385	452,385	3
4	V	32	Interest Exp House		Embassy Care Building Partnership		9,990	9,990	4
5	V	30	Depreciation		Embassy Care Building Partnership		78,862	78,862	5
6	V	33	RE Tax - Non Care		Embassy Care Building Partnership		3,072	3,072	6
7	V	31	Amortization		Embassy Care Building Partnership		527	527	7
8	V	6	Repairs & Maint		Embassy Care Building Partnership		514	514	8
9	V	21	Trust Fees		Embassy Care Building Partnership		150	150	9
10	V	21	Bank Charges		Embassy Care Building Partnership		632	632	10
11	V	32	Interest Exp		Embassy Care Building Partnership		23,397	23,397	11
12	V	31	Loan Costs		Embassy Care Building Partnership		2,250	2,250	12
13	V	32	Amort Mtge costs		Embassy Care Building Partnership		5,630	5,630	13
14	Total			$ 533,645			$ 577,396	$ * 43,751	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	FUTURE ASSOCIATES	100.00%	$ 2,873	$ 2,873	15
16	V	6	MAINTENANCE		FUTURE ASSOCIATES	100.00%	1,386	1,386	16
17	V	19	PROFESSIONAL FEES		FUTURE ASSOCIATES	100.00%	17,234	17,234	17
18	V	20	LICENSES, DUES, FEES		FUTURE ASSOCIATES	100.00%	423	423	18
19	V	21	CLERICAL & GENERAL		FUTURE ASSOCIATES	100.00%	113,822	113,822	19
20	V	22	EMPLOYEE BENEFITS		FUTURE ASSOCIATES	100.00%	25,033	25,033	20
21	V	25	AUTO		FUTURE ASSOCIATES	100.00%	9,000	9,000	21
22	V	26	INSURANCE		FUTURE ASSOCIATES	100.00%	3,216	3,216	22
23	V	30	DEPRECIATION		FUTURE ASSOCIATES	100.00%	13,565	13,565	23
24	V	32	INTEREST		FUTURE ASSOCIATES	100.00%	3,249	3,249	24
25	V	33	REAL ESTATE TAX		FUTURE ASSOCIATES	100.00%	7,199	7,199	25
26	V	35	EQUIPMENT RENTAL		FUTURE ASSOCIATES	100.00%	4,854	4,854	26
27	V	17	ADMINISTRATIVE		FUTURE ASSOCIATES	100.00%	49,840	49,840	27
28	V	21	CLERICAL & GENERAL		FUTURE ASSOCIATES	100.00%	17,188	17,188	28
29	V	22	EMPLOYEE BENEFITS		FUTURE ASSOCIATES	100.00%	1,365	1,365	29
30	V								30
31	V	17	MANAGEMENT FEES	315,406	FUTURE ASSOCIATES	100.00%		(315,406)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 315,406			$ 270,247	$ * (45,159)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Haim Perlstein	Director	Administrative	22.96	See attached	30	50.00	Alloc Future	$ 45,840	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 45,840		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd.
City / State / Zip Code: Skokie, Il
Phone Number: (847) 982-1195
Fax Number: (847) 982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Management Fees	925,144	4	$ 8,428	$	315,406	$ 2,873	1
2	6	MAINTENANCE	Management Fees	925,144	4	4,064		315,406	1,386	2
3	19	PROFESSIONAL FEES	Management Fees	925,144	4	50,550		315,406	17,234	3
4	20	LICENSES, DUES, FEES	Management Fees	925,144	4	1,241		315,406	423	4
5	21	CLERICAL & GENERAL	Management Fees	925,144	4	333,861	242,217	315,406	113,822	5
6	22	EMPLOYEE BENEFITS	Management Fees	925,144	4	73,426		315,406	25,033	6
7	25	SEMINAR	Management Fees	925,144	4	26,398		315,406	9,000	7
8	26	INSURANCE	Management Fees	925,144	4	9,432		315,406	3,216	8
9	30	DEPRECIATION	Management Fees	925,144	4	39,788		315,406	13,565	9
10	32	INTEREST	Management Fees	925,144	4	9,531		315,406	3,249	10
11	33	REAL ESTATE TAX	Management Fees	925,144	4	21,116		315,406	7,199	11
12	35	EQUIPMENT RENTAL	Management Fees	925,144	4	14,237		315,406	4,854	12
13	17	ADMINISTRATIVE	Direct Allocation	925,144	4	194,600			49,840	13
14	21	CLERICAL & GENERAL	Direct Allocation			42,969	42,969		18,553	14
15	22	EMPLOYEE BENEFITS	Direct Allocation			3,413				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 833,054	$ 285,186		$ 270,247	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$ 4,438,885		9.7500	$ 452,385	1
2	Success National Bank		X	Mortgage - Non Care asset	$933.00	04/01/96	120,000	115,138		8.6300	9,990	2
3												3
4												4
5												5
	Working Capital											
6	CIB Bank		X	Working Capital		12/99		491,802		Various	42,630	6
7	Hawthorne Bank		X	Working Capital				591,000		Various	23,397	7
8	Insurance Financing										3,063	8
9	TOTAL Facility Related				$44,153.44		$ 4,630,000	$ 5,636,825			$ 531,465	9
	B. Non-Facility Related*											
10	Supplemental Schedule										3,249	10
11	Interest Income Bldg Ptnshp										(13)	11
12	Non care Interest										(9,990)	12
13	Interest Income Entity										(43)	13
14	TOTAL Non-Facility Related						$	$			$ (6,797)	14
15	TOTALS (line 9+line14)						$ 4,630,000	$ 5,636,825			$ 524,668	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation from Future	x					$	$			$ 3,249	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 3,249	21

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	54,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	7,199	2
3. Under or (over) accrual (line 2 minus line 1).	$	(46,801)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	109,781	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	62,980	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,150	8
	1996	51,707	9
	1997	53,199	10
	1998	53,454	11
	1999	54,781	12

Estimate based on 1999 tax bill rounded to 55,000 + 1999 tax bill of 54,781.

Allocation from Future 7,199

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,635
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 2,777
4. Dates Incurred: 94-95;2000

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1993		$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 534,486	4
5											5
6			1986	Alloc. LCF	74,090	3,112	30	2,470	(642)	34,781	6
7			1987	Alloc. LCF	1,777	57	31.5	57		762	7
8											8
	Improvement Type**										
9	Various			1993	55,674	1,096	20	2,784	1,688	20,777	9
10	Various			1994	144,492	3,192	20	7,227	4,035	47,246	10
11	Various			1995	126,250	3,254	20	6,316	3,062	34,504	11
12	ROOFTOP UNIT E WING			1996	16,485	423	20	824	401	3,914	12
13	GAS LINE REPAIRS			1996	702	18	20	35	17	166	13
14	ELECTRICAL WIRING			1996	1,584	41	20	79	38	375	14
15	EXHAUST FANS VESTIBL			1996	3,200	82	20	160	78	760	15
16	A/C REPAIRS			1996	693	18	20	35	17	166	16
17	DOOR ALARM			1996	1,441	37	20	72	35	348	17
18	BATHROOM REFURBISHED			1996	5,800	149	20	290	141	1,402	18
19	WIRING			1996	540	14	20	27	13	122	19
20	TILES FLOORING			1996	3,089	79	20	154	75	770	20
21	SIDEWALL GRILLS			1996	740	19	20	37	18	151	21
22	2 5 ton air cond			1996	11,140	286	20	557	271	2,274	22
23	BUILD COPIER ROOM			1996	10,000	256	20	500	244	2,250	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				67,472	1,879		2,323	444	25,538	32
33	PAGE 12C TOTALS				77,351	307		698	391	852	33
34	PAGE 12B TOTALS				28,470	697		1,424	727	2,366	34
35	PAGE 12A TOTALS				59,114	1,415		2,959	1,544	12,243	35
36	TOTAL (lines 4 thru 35)				$ 3,053,104	$ 91,447		$ 96,542	$ 5,095	$ 726,253	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILTIN CABINETS			1996	6,500	167	20	325	158	1,463	9
10	SMITTYS			1996	577	15	20	29	14	128	10
11	REFINISH PARKING LOT			1996	13,900	356	20	695	339	3,185	11
12	EVAPORATOR INSTALLED			1996	1,192	31	20	60	29	275	12
13	ROOFTOP CORRIDOR			1996	5,285	136	20	264	128	1,188	13
14	TILE FLOORING			1996	913	23	20	46	23	219	14
15	A/C HEATING REPAIRS			1996	997	26	20	50	24	238	15
16	HANDRAILS			1996	1,058	27	20	53	26	230	16
17	WIRING NURSES STATIO			1996	5,780	148	20	289	141	1,276	17
18	PAINTING DECORATING			1996	1,444	37	20	72	35	324	18
19	CARPETING			1996	752	19	20	38	19	165	19
20	WIRING			1996	646	17	20	32	15	139	20
21	FIRE ALARM SERVICE			1997	915	23	20	46	23	176	21
22	ROOF COATING			1997	1,010	26	20	51	25	200	22
23	PLUMBING-PARTS			1997	836	21	20	42	21	147	23
24	SECURITY CAMERA			1997	1,156	30	20	58	28	227	24
25	ROOFTOP A/C UNIT			1997	6,145	158	20	307	149	1,202	25
26	PLUMBING-VALVE			1997	2,035	52	20	102	50	383	26
27	ROOF COATING			1997	1,250	32	20	63	31	242	27
28	PLUMBING-VALVE			1997	627	16	20	31	15	109	28
29	Electrical lines			1998	2,134	55	20	107	52	232	29
30	HVAC			1998	711		20	36	36	81	30
31	KEYPAD			1998	592		20	30	30	70	31
32	DEFROST CLOCK			1998	519		20	26	26	56	32
33	BOTTLES,CO2			1998	575		20	29	29	87	33
34	POLE CONTRACTORS			1998	589		20	29	29	70	34
35	MOTOR			1998	976		20	49	49	131	35
36	TOTAL (lines 4 thru 35)				$ 59,114	$ 1,415		$ 2,959	$ 1,544	$ 12,243	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CIRCUIT BREAKER			1998	634		20	32	32	75	9
10	New doors			1998	1,999	51	20	100	49	225	10
11	Firelite panel			1998	1,551	40	20	78	38	176	11
12	Alarm System			1998	592	15	20	30	15	70	12
13	Electrc Outlets			1998	634	16	20	32	16	75	13
14	Floor Drain			1998	1,629	42	20	81	39	236	14
15	CIRCUIT BOARD			1998	559		20	28	28	61	15
16	Outlets and Cable			1999	825	21	20	41	20	55	16
17	Couplings, Mounts			1999	526	13	20	26	13	46	17
18	Nurse call system			1999	634	16	20	32	16	43	18
19	Roof Top Units			1999	553	14	20	28	14	30	19
20	Window Glass			1999	645	17	20	32	15	43	20
21	New Drain Pipe			1999	3,000	77	20	150	73	188	21
22	Carrier Board			1999	668	17	20	33	16	39	22
23	Water Main			1999	683	18	20	34	16	40	23
24	Rep. 2.5 WaterMain"			1999	2,200	56	20	110	54	128	24
25	Extend PA System			1999	1,381	35	20	69	34	81	25
26	Floor Water Leak			1999	1,175	30	20	59	29	118	26
27	Fire Alarm System			1999	1,220	31	20	61	30	71	27
28	Rear Door Alarm			1999	876	22	20	44	22	81	28
29	Door Lock System			1999	1,463	38	20	73	35	85	29
30	Cable, Outlets - DON			1999	557	14	20	28	14	37	30
31	Fire Alarm Cables			1999	887	23	20	44	21	81	31
32	Alarm System			1999	721	18	20	36	18	39	32
33	New Cable For PA Sys			1999	624	16	20	31	15	57	33
34	Fire Alarm Door			1999	711	18	20	36	18	66	34
35	Heat sensors			1999	1,523	39	20	76	37	120	35
36	TOTAL (lines 4 thru 35)				$ 28,470	$ 697		$ 1,424	$ 727	$ 2,366	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wood Door			1999	932	24	20	47	23	78	9
10	Shower Faucets			1999	1,717	44	20	86	42	172	10
11	Boiler			1999	5,455	140	20	273	133	296	11
12	Heat Detectors			1999	650	17	20	33	16	47	12
13	New Grease Trap			2000	15,037	16	20	63	47	63	13
14	Hot water heater			2000	2,500	8	20	42	34	42	14
15	Clean floors			2000	872	14	20	58	44	58	15
16	100 A 240 V 3 POLE			2000	809	11	20	23	12	23	16
17	Nurse call system			2000	750	2	20	6	4	6	17
18	Install h/water htr			2000	850	3	20	7	4	7	18
19	Single stage furnace			2000	2,891	28	20	60	32	60	19
20	Painting & Decorating			2000	44,888		20				20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 77,351	$ 307		$ 698	$ 391	$ 852	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation from LCF			1987	10197	324	32	324		4,289	10
11	Allocation from LCF			1988	573	18	315	18		224	11
12	Allocation from LCF			1989	213	7	32	7		76	12
13	Allocation from LCF			1993	5923	152	39	152		1,118	13
14	Allocation from LCF			1994	9031	231	39	231		1,494	14
15	Allocation from Future			1987	32,136	1,020	32	1,020		14,411	15
16	Allocation from Future			1994	9,399	127	32	571	444	3,926	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 67,472	$ 1,879		$ 2,323	$ 444	$ 25,538	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 694,865	$ 20,045	$ 68,572	$ 48,527		$ 465,856	37
38	Current Year Purchases	56,184	10,624	4,469	(6,155)		4,469	38
39	Fully Depreciated Assets	40,632	102	163	61		40,632	39
40								40
41	TOTALS	$ 791,681	$ 30,771	$ 73,204	$ 42,433		$ 510,957	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Bus	1993 Ford Bus	1998	$ 1,200	$ 230	$ 230	$	5	$ 854	42
43	Alloc from Future Assoc			49,782	3,980	5,609	1,629	5	24,409	43
44										44
45										45
46	TOTALS			$ 50,982	$ 4,210	$ 5,839	$ 1,629		$ 25,263	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	4,040,767	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	126,428	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	175,585	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	49,157	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,262,473	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	House	$ 150,000	$ 3,846	$ 18,108	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 150,000	$ 3,846	$ 18,108	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

EMBASSY CARE CENTER, INC.
0038711
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Embassy Care Center, Inc	244,876	16,675	24,443	7,768	115,123
Embassy Building	392,000		39,200	39,200	310,333
Future Associates	57,989	3,370	4,929	1,559	40,400
TOTALS	694,865	20,045	68,572	48,527	465,856
LINE 29: CURRENT YEAR					
Embassy Care Center, Inc	50,864	9,560	4,203	(5,357)	4,203
Embassy Building					
Future Associates	5,320	1,064	266	(798)	266
TOTALS	56,184	10,624	4,469	(6,155)	4,469
LINE 30: FULLY DEPRECIATED					
Embassy Care Center, Inc	2,244				2,244
Embassy Building					
Future Associates	38,388	102	163	61	38,388
TOTALS	40,632	102	163	61	40,632
TOTALS (Should Tie to Totals on Page 13)					
Embassy Care Center, Inc	297,984	26,235	28,646	2,411	121,570
Embassy Building	392,000		39,200	39,200	310,333
Future Associates	101,697	4,536	5,358	822	79,054
TOTALS	791,681	30,771	73,204	42,433	510,957

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc from Future Assoc		$	$ 4,854	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,854	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 18,379	$		$ 18,379	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,986			3,986	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			42,653			42,653	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				105,768		105,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-3				604	15,745		16,349	13
14	TOTAL			$		$ 65,622	$ 121,513		$ 187,135	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	717
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	570
5	Medical and Surgical Expense	14,458
6		
7		
8		
9		
10		
		15,745

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2	Medicare - Other	604
3		
4		
5		
6		
7		
8		
9		
10		
		604

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 673,355	$ 675,662	1
2	Cash-Patient Deposits	33,737	33,737	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,814	603,429	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,979	120,979	6
7	Other Prepaid Expenses	2,311	2,311	7
8	Accounts Receivable (owners or related parties)	20,791	2,741,684	8
9	Other(specify): See supplemental schedule	34,808	43,223	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,474,795	$ 4,221,025	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		145,000	13
14	Buildings, at Historical Cost		2,513,000	14
15	Leasehold Improvements, at Historical Cos	453,506	453,506	15
16	Equipment, at Historical Cost	324,403	716,403	16
17	Accumulated Depreciation (book methods)	(317,368)	(1,318,227)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,635	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,753)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		106,976	22
23	Other(specify): See supplemental schedule	6,378	6,378	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 466,919	$ 2,626,918	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,941,714	$ 6,847,943	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,417,773	$ 1,417,773	26
27	Officer's Accounts Payable	664,109	664,109	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	491,802	1,082,802	29
30	Accrued Salaries Payable	215,693	215,693	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,756	9,756	31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,781	109,781	32
33	Accrued Interest Payable		42,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	13,348	38,921	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,922,262	$ 3,581,449	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,554,023	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,554,023	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,922,262	$ 8,135,472	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (980,548)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,941,714	$ #REF!	48

*(See instructions.)

Facility Name & ID Number EMBASSY CARE CENTER, INC. **#** 0038711 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	22,073	30,488
Employee Advances	217	217
Deferred Federal Taxes	12,518	12,518
	34,808	43,223

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax -		
Non Care Property		3,500
Capital Lease Obligation	13,348	13,348
Tenants Tax Deposit		22,073
	13,348	38,921

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit	3,478	3,478
Loan Costs		
Exchange	2,900	2,900
	6,378	6,378

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (720,804)	1
2	Restatements (describe):		2
3	**Schedule attached**	(18,068)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (738,872)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,676)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (241,676)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (980,548)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	EMBASSY CARE CENTER, INC.	#	0038711	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(738,872)
Adjustments:		
		-
		-
		-
Correct PTF Liability		12,414
Correct prior Year's Accounts Receivable		(59,543)
Additional write offs		196
Round off adj		1
Add back Allowance for Bad Debts		65,000
Total adjustments		18,068
Balance - Beginning of Year		(720,804)
Equity(Deficit) from Page 17 Col 1		(980,548)
Related Party		
Equity(Deficit)	-306983	
Income	0	
		(306,983)
Combined Equity - End of Year		(1,287,531)

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,356,998	1
2	Discounts and Allowances for all Levels	(231,756)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,125,242	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	186,580	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 186,580	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,183	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,996	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	41,694	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 181,873	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	30,254	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 30,254	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,523,992	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	849,680	31
32	Health Care	1,824,805	32
33	General Administration	1,136,097	33
	B. Capital Expense		
34	Ownership	672,967	34
	C. Ancillary Expense		
35	Special Cost Centers	188,239	35
36	Provider Participation Fee	93,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,765,668	40
41	**Income before Income Taxes (line 30 minus line 40)****	(241,676)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (241,676)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	775
2	Prior Period Adjustments - Income	15,180
3	Income Day Training	14,299
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	30,254

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,862	2,123	$ 43,198	$ 20.35	1
2	Assistant Director of Nursing	497	714	11,117	15.57	2
3	Registered Nurses	10,609	12,065	208,237	17.26	3
4	Licensed Practical Nurses	19,373	20,326	313,434	15.42	4
5	Nurse Aides & Orderlies	55,456	58,674	526,896	8.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,164	6,854	86,427	12.61	8
9	Activity Director	4,208	4,797	37,945	7.91	9
10	Activity Assistants	11,945	12,785	103,558	8.10	10
11	Social Service Workers	5,637	6,300	54,050	8.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,696	27,219	203,327	7.47	15
16	Dishwashers					16
17	Maintenance Workers	4,201	4,388	43,967	10.02	17
18	Housekeepers	15,711	16,517	108,189	6.55	18
19	Laundry	10,139	10,727	69,938	6.52	19
20	Administrator	2,507	2,939	57,344	19.51	20
21	Assistant Administrator	2,088	2,151	38,889	18.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,056	9,184	91,291	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	183,149	197,763	$ 1,997,807 *	$ 10.10	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 7,800	1-3	35
36	Medical Director	Monthly	12,500	9-3	36
37	Medical Records Consultant	19	1,034	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,650	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	137	7,269	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	255	10a-3	43
44	Activity Consultant	65	3,701	11-3	44
45	Social Service Consultant	39	2,150	12-3	45
46	Other(specify)				46
47	Psycho social	16	904	12-3	47
48					48
49	TOTAL (lines 35 - 48)	473	$ 37,263		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	486	$ 19,437	10-3	50
51	Licensed Practical Nurses	3,305	115,669	10-3	51
52	Nurse Aides	9,510	180,034	10-3	52
53	TOTAL (lines 50 - 52)	13,301	$ 315,140		53

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Bersted (7/31/00-12/31/00)	Administrator		$ 17,705
William McNiff(01/01-05/31/00)	Administrator		24,000
Rebecca Halderson (6/1/00-7/30/00)	Administrator		15,639
Rebecca Halderson (1/1/00-5/31/00)	Asst Admin		19,000
Kim Forrest (6/1/00-12/31/00)	Asst Admin		19,889
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,233

B. Administrative - Other

Description	Amount
Future Associates	$ 315,406
TOTAL (agree to Schedule V, line 17, col. 3)	$ 315,406
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Acctg	$ 63,855
Schwartz & Freeman	Legal	3,154
Holleb & Coff	Legal	3,190
Sachnoff & Weaver	Legal	14,518
Personnel Planners	UC Consultant	1,171
Trust Fees	Trust Fees	1,015
Various Data Proc Companies	Data Processing	13,887
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 100,790

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,939
Unemployment Compensation Insurance	14,037
FICA Taxes	152,832
Employee Health Insurance	80,053
Employee Meals	20,917
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	17,502
Holiday Expense	9,907
Alloc from Future	26,398
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,585

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,262
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promotion	11,880
Licenses & Fees	1,293
Dues & Subscriptions	7,269
ILCLTC	(108)
Alloc from Future	423
Less: Public Relations Expense	(1,984)
Non-allowable advertising	(9,896)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,139

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,495
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,495

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & decoratinf	6/99	$ 16,586	3	$	$	$ 2,764	$ 5,529	$ 5,529	$ 2,764	$	$	$
2													
3													
4													
5													
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19													
20	TOTALS		$ 16,586		$	$	$ 2,764	$ 5,529	$ 5,529	$ 2,764	$	$	$

Facility Name & ID Number EMBASSY CARE CENTER, INC. # 0038711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Ill Council LTC 6438**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,219** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **93,879**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **20,917** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw